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Private or Public Insurance? The Institutional History of Health Care in the United States and the United Kingdom

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PRIVATE OR PUBLIC INSURANCE? THE INSTITUTIONAL HISTORY OF
HEALTH CARE IN THE UNITED STATES AND THE UNITED KINGDOM

by

Karin M. Abel

A thesis submitted in partial fulfillment
of the requirements for the degree

of

MASTER OF SCIENCE

in

Sociology

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ABSTRACT

Private or Public Insurance? The Institutional History of Health
Care in the United States and the United Kingdom

by

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Utah State University, 2010

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Program: Sociology

The primary question at issue in this paper is the following: given the similarities between the two countries with regard to welfare state institutions, why have the United States and the United Kingdom diverged on the issue of health care? Drawing on sociological institutionalism, a branch of the new institutionalist paradigm, this paper provides an answer to this question: during the formative years of the health care stories in the two countries, variations in institutional and cultural conditions produced contrasting policy outcomes. More specifically, this paper discusses how the combination of institutions (political, labor, and medical) and culture led to private insurance in the United States and public insurance in the United Kingdom. Of course, this paper has implications for several areas of scholarship, as well as for current policy debates on a wide range of issues.

(72 pages)

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Karin M. Abel

CONTENTS

	Page
ABSTRACT.....	iii
ACKNOWLEDGMENTS	iv
LIST OF TABLES.....	vi
INTRODUCTION	1
THEORY	4
Institutions.....	8
Culture.....	12
METHODS	14
Approach.....	14
Data Collection Procedures.....	14
Propositions and Variables	14
Relationships Between Variables	17
Analysis.....	18
Weaknesses and Strengths of Research Design.....	18
Ethical Considerations	19
COUNTRY CASE STUDIES.....	20
United States	20
United Kingdom.....	39
CONCLUSION.....	57
REFERENCES	60

LIST OF TABLES

Table		Page
1	Esping-Andersen's "Three Worlds" Typology.....	5
2	Propositions and Variables	15

INTRODUCTION

Although they have much in common when it comes to the role of the state in society, the United States and the United Kingdom have vastly different health care systems. General *government* expenditure on health care as a percent of *total* expenditure on health care is much less in the United States than in the United Kingdom (World Health Organization 2009). In other words, the private sector plays a significant part in the administration of health care in the United States, whereas health care is primarily a public responsibility in the United Kingdom. Generally speaking, in the United States, the individual must acquire health insurance on his/her own, either through employment or some other means. Alternatively, in the United Kingdom, the government uses tax revenues to fund most health care (Raffel 1997). Given the similarities between these two countries with regard to welfare state institutions, why have they diverged on the issue of health care?

Gaining a better understanding of the origin/evolution of health care systems is important for at least two reasons: (1) history shapes contemporary realities, and (2) history provides a context for efforts to enact social change. With regard to the first reason, evidence suggests that the current health care systems in the United States and the United Kingdom vary in several ways, including access and outcomes. Problems related to access exist in both countries, but the sources of these problems are not the same. A central concern in the United States is financial access. Patients are at particularly high risk of foregoing care due to cost (Blendon et al. 2002; Donelan et al. 1999; Schoen and Doty 2004; Schoen et al. 2005; 2007; 2009). In the United Kingdom, on the other hand, individuals with below- and above-average incomes have comparable access to health

care services (Schoen and Doty 2004). While barriers that stem from cost are virtually nonexistent in the United Kingdom, lack of access as a result of waiting times is a problem. In distinction, waiting times in the United States are often shorter than in the United Kingdom (Adeniran 2004; Blendon et al. 2002; Carroll et al. 1995; Donelan et al. 1999).

With respect to health outcomes, the United Kingdom fares slightly better than the United States on infant mortality rate and life expectancy at birth, two good indicators of overall population health (World Health Organization 2009). However, these differences are not necessarily the result of variation in health care systems. Other factors (e.g., lifestyle choices) may be to blame. A more meaningful approach might be to examine the ways in which inequality within each health care system affects health outcomes. In the United States, tens of millions of people have no health insurance (DeNavas-Walt, Proctor, and Smith 2009). Additionally, uninsured individuals are at greater risk for negative health outcomes than those with insurance (Franks, Clancy, and Gold 1993). In contrast, in the United Kingdom, universal coverage ensures that all have access to at least some form of health insurance. Interestingly, individuals who obtain supplemental private insurance do not gain an advantage on access or quality of care measures over those who have only public insurance (Schoen and Doty 2004). It seems likely, then, that differences in health outcomes in the United Kingdom may not be as strongly linked to the health care system as is the case in the United States. Clearly, the US and UK health care systems vary in terms of access and outcomes.

As for the second reason, understanding the origin/evolution of health care systems is vital to determining avenues for future social change. Analysis of past efforts

to shape health care systems offers a baseline from which to evaluate the prospects of present proposals for reform. This point is especially applicable now since the United States is in the midst of a debate about health care reform. (Although President Barack Obama's health care proposal recently became law, several states are in the process of challenging the constitutionality of the legislation [Richey 2010].) Through an increased understanding of how health care systems form, important stakeholders may be better able to identify the range of institutional possibilities.

As extant literature on health care systems largely focuses on the operation and/or effectiveness of established programs, this paper makes a meaningful contribution to health studies in that it deals with the origin/evolution of health care systems. The sections that follow provide a historical-comparative analysis of the US and UK health care systems. After establishing that the United States and the United Kingdom have much in common when it comes to welfare state institutions, this paper draws on the new institutionalist paradigm to help explain why the US and UK health care systems are on different trajectories.

THEORY

In his book entitled *The Three Worlds of Welfare Capitalism*, Esping-Andersen (1990) introduces a threefold typology of social democratic, conservative, and liberal welfare regimes. “‘Regimes’ refers to the ways in which welfare production is allocated between state, market, and households” (Esping-Andersen 1999:73). The key defining dimensions of this “three worlds” typology are degree of decommodification and modes of stratification. Decommodification occurs when services are considered a matter of right, and individuals can maintain a socially acceptable standard of living independently of market participation. With regard to stratification, the welfare state is not just a mechanism that limits inequality; rather, the welfare state is a system of stratification in its own right in that it may stigmatize recipients of services (Esping-Andersen 1990).

Level of decommodification and modes of stratification vary across the three welfare regimes, contributing to different arrangements between state, market, and family. High decommodification, strong universalism, and marginalization of private welfare characterize the social democratic welfare regime. The conservative welfare regime is modestly decommodifying and corporatist. Benefits are associated with occupational status. This type of regime also emphasizes familialism. Parents (or children) must be responsible for their children (or parents) if needs arise. The state intervenes only when the family’s capacity to take care of its members is exhausted. The liberal welfare regime limits decommodification-effects, stressing the minimization of the role of the state, individualization of risks, and promotion of market solutions. This regime type views citizens’ entitlements with disfavor. Only when the market fails does

the state act (Esping-Andersen 1990; 1999). Table 1 summarizes Esping-Andersen's "three worlds" typology.

Table 1. Esping-Andersen's "Three Worlds" Typology

Regime Type	Degree of Decommodification	Stratification Effects	State-Market-Family Relations
Social Democratic	High decommodification; universal entitlements	Low poverty/inequality; marginalization of private welfare	Full employment policies are key distributive mechanism
Conservative	Moderate decommodification; entitlements associated with occupational status (corporatism)	Ordered inequality; traditional status relations	State intervenes only when family's capacity to take care of its members exhausted (familialism)
Liberal	Low decommodification; entitlements based on demonstrable and abject need	High poverty/inequality; stigma attached to social assistance	State intervenes only when market fails

According to Esping-Andersen (1990; 1999), both the United States and the United Kingdom are liberal welfare regimes. Moreover, there is broad consensus that the two countries fall under the same general category on the issue of welfare state provision (Arts and Gelissen 2002; Esping-Andersen 1990; 1999; Powell and Barrientos 2004). The fact that the United States and the United Kingdom are often grouped together in the welfare state literature suggests that the two countries have reached comparable policy outcomes on multiple occasions. For example, relative to many other countries, both the United States and the United Kingdom are extraordinarily biased toward targeted social assistance programs (i.e., needs-based [as opposed to rights-based] assistance programs). The two countries also favor a private welfare approach when it comes to the matter of pensions. In terms of family welfare provision, both the United States and the United Kingdom offer little public support as it relates to care for the elderly (Esping-Andersen

1999). Given the similarities between the two countries with regard to welfare state institutions, why have the United States and the United Kingdom taken such different paths on the issue of health care? Attempting to answer this question through the lens of new institutionalism may offer some valuable insight.

The new institutionalist paradigm provides the theoretical underpinnings for a large body of work in sociology (e.g., Brinton and Nee 1998). A response to the political behavior movement of the 1950s and 1960s, new institutionalism strongly rejects “observed behavior as the basic datum of political analysis” (Immergut 1998:6). Instead, the new institutionalist paradigm argues that behavior occurs in the context of institutions; therefore, institutions should be the primary focus of attention (Immergut 1998). Although it presumes purposive action on the part of individuals, new institutionalism takes into account the concept of context-bound rationality. The new institutionalist paradigm, then, involves integrating the choice-theoretic tradition with comparative institutional analysis (Nee 1998).

Hall and Taylor (1996) identify three varieties of new institutionalism: historical institutionalism, rational choice institutionalism, and sociological institutionalism. All three schools of thought are concerned with the role that institutions play in the determination of social and political outcomes. While they overlap in some respects, the three new institutionalist approaches also have their differences. Historical institutionalism is especially attentive to the ways in which the unequal distribution of power affects outcomes. Another component of historical institutionalism is the concept of path dependency. Mahoney (2000:507) states that “path dependence characterizes specifically those historical sequences in which contingent events set into motion

institutional patterns or event chains that have deterministic properties.” In other words, early choices and events shape the subsequent development of institutions and policies. Historical institutionalism also focuses on the relationship between institutions and beliefs (Hall and Taylor 1996).

Rational choice institutionalism borrows from exchange theory. This school of thought assumes that individuals aim to maximize the attainment of their own preferences. Under this model, the role of institutions is to reduce the uncertainty present during interactions. In the process of competitive selection, the institutions that provide the most benefits to relevant individuals are the ones that tend to persist (Hall and Taylor 1996).

Sociological institutionalism seeks to break down “the conceptual divide between ‘institutions’ and ‘culture’” (Hall and Taylor 1996:947). Stated another way, culture influences the form institutions take, and institutions reinforce culture. Institutions are not as concerned with means-ends efficiency as they are with social legitimacy. As such, they generally adopt practices that are acceptable within the broader cultural environment. In short, culture determines the social legitimacy of institutional arrangements (Hall and Taylor 1996).

While all three varieties of new institutionalism are relevant to the study of health care systems, this paper mainly draws on sociological institutionalism. With regard to the origin/evolution of health care systems, two questions are of central importance: (1) which institutions matter, and (2) what is the role of culture?

Institutions

As to the first question, this paper discusses the impact of political, labor, and medical institutions on the formation of health care systems. Political institutions are of interest because they are the location of policymaking. The US system of checks and balances makes it hard to enact and implement policies. A two-party dynamic encourages members of both parties to avoid taking risks, so bold reforms are especially difficult to achieve. Even when dominated by the same party as the executive, Congress has considerable autonomy. Put another way, achieving unity on a given issue is challenging. To complicate circumstances, all kinds of interest groups have many opportunities throughout the lawmaking process to derail proposals. Politicians regularly introduce major proposals; however, these proposals rarely become law. State politics often follow a similar pattern (Sakala 1990).

The situation in the United Kingdom is much different. In the UK parliamentary system, the party that wins the most seats in the House of Commons gains control of the government and chooses the prime minister. The UK executive and assembly can work together to implement policies consistent with the platform upon which the party was brought into office. The absence of a strictly two-party dynamic improves the prospects of bold reforms, and limitations on interest group participation increase the likelihood of legislative success (Sakala 1990). Surely, then, the structure of political institutions is a major contributor to change in health care systems over time. *From this discussion on political institutions, a proposition emerges: political structures that have more autonomous institutional layers are less likely to implement universal health care.*

As for labor institutions, Esping-Andersen (1990:1) argues “that the history of political class coalitions is the most decisive cause of welfare-state variations.” The extent to which workers are able to, first, unite in purpose and, second, build broad-based coalitions has implications for welfare-state development (Esping-Andersen 1990). Skocpol (1992) suggests that experiences in two different national political systems prompted the US and UK labor movements to take on distinct structural forms. For the last couple decades of the nineteenth century, the US labor movement was a viable political force. Mainstream political parties often sought labor votes. Moreover, in many parts of the country, independent labor and populist parties were thriving. As a result, American unions were able to achieve many legislative victories. Around the turn of the twentieth century, though, adverse electoral shifts led to less competitive elections. Consequently, the US labor movement’s political influence declined. In an effort to retain the greatest political leverage possible, unions all over the country developed mutually beneficial relationships with local entities, making any unified national campaign on labor’s behalf extremely unlikely.

In addition, throughout this time period, the US labor movement was in a constant battle with the courts. Eventually, many labor leaders concluded that reform through legislation was a waste of time (Skocpol 1992). As Skocpol (1992:227) states, “Bitter experiences with the courts could sour labor leaders on the very idea of working for change through elections and legislatures.” Accordingly, the US labor movement turned to market unionism and collective bargaining (Skocpol 1992).

In sharp contrast, the UK labor movement found political involvement rewarding. As they operated under a unitary and centralized system of government, all British unions

were subject to the same laws and judicial rulings. Therefore, the UK labor movement was able to unite around a common set of political objectives. During the latter half of the nineteenth century, to ensure their basic institutional security, British unions created the Trades Union Congress, campaigned for the election of labor-friendly parliamentary candidates, and established a national committee to lobby and monitor Parliament. At the turn of the twentieth century, they set up the Labour Representation Committee, precursor to the Labour Party (Skocpol 1992).

Ultimately, the UK labor movement was able to secure meaningful representation in Parliament. British unions' parliamentary allies reversed unfavorable judicial decisions and enacted social legislation consistent with labor's interests. As a result of these developments, the UK labor movement determined that reform through legislation was an effective option. In other words, British unions believed that labor unity on the national level had the potential to produce favorable outcomes (Skocpol 1992). Labor movement structure, then, is likely a significant factor in the formation of health care systems over time. *Another proposition emerges from this discussion on labor institutions: labor movements that are more fragmented are less likely to achieve universal health care.*

As distributors of health services and key players in the development of health technology, medical institutions are a vital element of any discussion that deals with the origin/evolution of health care systems. Since they are at the center of many people's interactions with health care systems, physicians are of particular importance. A crucial component of the patient-physician relationship is trust. One of the sources of this trust is professional authority. For much of the nineteenth century, US physicians struggled to attain professional authority; in the end, they were successful in this endeavor (Starr

1982). According to Starr (1982:18), “The forces that transformed medicine into an authoritative profession involved both its internal development and broader changes in social and economic life.” For instance, people began to view science as superior to other forms of knowledge, making physicians’ interpretations of experiences a valuable commodity. Similarly, advances in technology increased the plausibility of physicians’ claims to competent authority (Starr 1982).

The institutionalization of standardized programs of licensing and education also had an impact (Starr 1982). As Moran (1999:42) states, “In a society with an egalitarian culture and a weak federal government, the problem of controlling and legitimising medical authority could only be tackled at the level of individual states, and by working to some low common denominator of medical competence.” This being the case, a licensing movement spread through individual states. State licensing boards became the key bodies in a greatly decentralized regulatory structure. To be eligible for licensing, individuals had to meet the requirements of a licensed medical school. By the turn of the twentieth century, American Medical Association (AMA) members controlled the state licensing boards. Shortly thereafter, the AMA emerged on the national scene as an authoritative voice on health matters (Moran 1999).

Medicine’s fight for professional authority in the United Kingdom began during the sixteenth century. In 1518, London physicians secured the charter for the Royal College of Physicians. While it primarily benefited a small elite group, this charter was a step toward legitimacy for UK physicians on the whole (Moran 1999). “The critical event in creating the institutionally privileged position of medicine, however, was the passage of the 1858 Medical Act” (Moran 1999:29). The Act created a regulatory body known as

the General Council of Medical Education and Registration. The mark of a qualified physician was entry onto the Council's register. In conjunction with the implementation of the Act, teaching hospitals, and later universities, assumed the responsibility of medical education. The end result was a centralized regulatory structure that reinforced the professional authority of UK physicians (Moran 1999). Once they have professional authority, physicians can likely influence social and political outcomes in the realm of health care. For this reason, physicians' interests matter. *The following proposition emerges from this discussion on medical institutions: medical organizations that have more power to pursue their own interests independent of the state are less likely to support universal health care.*

Culture

With regard to the second question, sociological institutionalism contends that institutions and culture are intertwined. Existing culture shapes the form particular institutions take; these institutions then support the establishment of other institutions that are consistent with the culture (Hall and Taylor 1996). In terms of this paper, a country's political, labor, and medical institutions evolve out of a broader cultural environment. Subsequently, they support the formation of health care institutions that are culturally reinforcing. The United States and the United Kingdom are dramatically different when it comes to culture. "Born out of revolution, the United States is a country organized around an ideology which includes a set of dogmas about the nature of a good society" (Lipset 1996:31). The country's founders took a deliberate turn away from the British model. In contrast to a centralized monarchical state, they created a weak and internally discordant

political system. In the United States, individual rights are of supreme importance; equality of opportunity and respect, not of result or condition, is paramount; and an empowered citizenry is fundamental. In short, an anti-statist culture is dominant (Lipset 1996).

In the United Kingdom, national identity is rooted in history not ideology. In other words, nationality is related to community, as opposed to an ideological commitment to a particular set of values. A country with a monarchical tradition, the United Kingdom demands a greater awareness of class divisions, as well as a stronger respect for the state, than does the United States. An anti-statist attitude is not ubiquitous (Lipset 1996). In all likelihood, culture plays a role in the origin/evolution of health care systems. The state is often the vehicle through which the implementation/administration of universal health care takes place. Strong anti-statist sentiment probably makes it difficult for the state to assume these responsibilities. *Based on this discussion of culture, a final proposition emerges: cultural environments that project more anti-statist sentiment are less likely to facilitate universal health care.*

To summarize, the United States and the United Kingdom are similar in terms of broader welfare state institutional approaches (Arts and Gelissen 2002; Esping-Andersen 1990; 1999; Powell and Barrientos 2004). That said, the United States and the United Kingdom have vastly different health care systems. Sociological institutionalism, a branch of the new institutionalist paradigm, offers potential insight into why these two countries have diverged on the issue of health care. This theoretical framework suggests that institutions and culture matter when it comes to the origin/evolution of the US and UK health care systems.

METHODS

Approach

This paper applies the historical-comparative approach to the study of health care systems. This approach is appropriate for comparing entire social systems, as well as for examining the combinations of social factors that contribute to specific outcomes. Historical-comparative research seeks to identify what is common across societies and what is unique. This type of research also aims to study long-term societal change (Neuman 2006). Given that the goal of this paper is to explain why the United States and the United Kingdom are on different health care paths, the historical-comparative approach is ideal.

Data Collection Procedures

In this paper, nations are the units of analysis; the two nations of interest are the United States and the United Kingdom. As they identify significant historical and institutional factors that are important to the formation of health care systems, historical accounts and scholarly journals are the main data sources of this paper.

Propositions and Variables

This paper's variables come from four propositions. (See the "Theory" section.) Table 2 lists these propositions, as well as the corresponding variables. Below Table 2 is a brief description of each variable.

Table 2. Propositions and Variables

Proposition	Variables
Political structures that have more autonomous institutional layers are less likely to implement universal health care.	Autonomous institutional layer; universal health care
Labor movements that are more fragmented are less likely to achieve universal health care.	Labor movement fragmentation; universal health care
Medical organizations that have more power to pursue their own interests independent of the state are less likely to support universal health care.	Medical power; universal health care
Cultural environments that project more anti-statist sentiment are less likely to facilitate universal health care.	Anti-statist sentiment; universal health care

Autonomous institutional layer. This variable is mainly tied to lawmaking processes. When it comes to lawmaking, the US system of checks and balances and the UK parliamentary system operate differently. However, in both countries, a proposal must gain the approval of multiple government bodies in order to become law. In general, bodies that are independently elected and have veto power constitute autonomous institutional layers. Even if they are unelected and not directly involved in lawmaking processes, bodies that operate independently and have veto power are also autonomous institutional layers. This paper seeks to determine whether or not variations in the number of autonomous institutional layers had an impact on the fate of specific policy proposals in the United States and the United Kingdom.

Labor movement fragmentation. This variable deals with the degree to which there is ideological unity across labor movements. Fragmented labor movements tend to take an insular, self-interested, firm-by-firm approach to issues, as opposed to a coalition-building approach. This paper addresses the role that variations in labor movement fragmentation played in particular policy outcomes in the United States and the United Kingdom.

Medical power. This variable is concerned with the extent to which medical organizations are able to pursue their own interests independent of the state. Medical power is a reflection of the nature of the relationships medical organizations have with other entities and/or an indication of the financial resources medical organizations have at their disposal. This paper examines the ways in which variations in medical power influenced specific policy outcomes in the United States and the United Kingdom.

Anti-statist sentiment. This variable focuses on the level of anti-statist sentiment that is present in cultural environments. Anti-statist cultural environments have the following characteristics: a focus on individual rights; an emphasis on equality of opportunity and respect, not of result or condition; and/or an aversion to centralized control. One of the avenues through which anti-statist sentiment reveals itself is the cultural framing of arguments. This paper analyzes the ways in which variations in cultural framing shaped particular policy outcomes in the United States and the United Kingdom.

Universal health care. This variable refers to health care coverage that is based on residence rights not on the purchase of insurance. For the most part, funding for this health care coverage comes from general taxation. The primary aim of this paper is to explain variations in this variable as they relate to the United States and the United Kingdom.

Relationships Between Variables

The propositions (see the “Theory” section and/or the “Propositions and Variables” portion of the “Methods” section) indicate expected relationships between variables. What follows is a discussion of the implications of each proposition.

Political structures that have more autonomous institutional layers are less likely to implement universal health care. With more autonomous institutional layers with which to contend, American reformers likely faced obstacles that their British counterparts were able to avoid. In the United States, at every autonomous institutional layer, opponents probably took advantage of the potentially many opportunities they had to stop bold health care initiatives from advancing. In the United Kingdom, on the other hand, opponents likely had an extremely limited number of chances to derail policy proposals.

Labor movements that are more fragmented are less likely to achieve universal health care. With an insular, self-interested, firm-by-firm approach to issues, the US labor movement was probably not inclined to pursue universal health care. Alternatively, with the ability to unite at the national level, the UK labor movement likely had a legitimate opportunity to push for universal health care.

Medical organizations that have more power to pursue their own interests independent of the state are less likely to support universal health care. American medical organizations probably had the power to achieve their objectives without the state’s assistance. Therefore, they were likely not interested in lending their support to bold health care policy initiatives. In contrast, British medical organizations probably

needed the state's help to reach their goals. As such, they were likely open to the idea of state intervention on health care.

Cultural environments that project more anti-statist sentiment are less likely to facilitate universal health care. In debates about health care, relevant parties in the United States probably relied more on anti-statist sentiment than did their counterparts in the United Kingdom. Through the use of anti-statist arguments, relevant parties in the United States were likely able to prevent health care measures from gaining the support necessary to secure passage. In distinction, relevant parties in the United Kingdom probably stayed away from anti-statist rhetoric, making the passage of legislation that called for a strong government role more likely to gain approval.

Analysis

This paper uses the “most similar case comparison” analytic strategy. This strategy implies the selection of two very similar cases. These two cases should be alike in most ways but vary in the area of inquiry. In terms of this paper, the United States and the United Kingdom are similar when it comes to welfare state provision. However, these two countries have diverged on the issue of health care. The goal of this paper is to determine what accounts for this variation on health care.

Weaknesses and Strengths of Research Design

This paper has three potential weaknesses. First, the focus here is on just two countries. Working with a small number of cases, it may be difficult to recognize competing explanations (e.g., demographics) for certain outcomes. With a larger sample, identifying all contributing factors to the origin/evolution of health care systems may be

easier to achieve. A contributing factor that is apparent in one case may not be so obvious in another. Second, given the small number of cases and the particular aspects of these cases, the results may not be generalizable. That said, some of the results may inform health policy in other countries, as well as other studies that deal with health care systems. Third, it may be difficult to create clear constructs that represent complex concepts. For example, accurately portraying what constitutes “labor movement fragmentation” is not an easy task to accomplish.

This paper also has three principal strengths. First, the use of Esping-Andersen’s “three worlds” typology makes it possible to state with confidence that the United States and the United Kingdom have much in common, except perhaps on the issue of health care. Second, the utilization of the new institutionalist paradigm, particularly sociological institutionalism, offers an opportunity to inform theory. Third, the historical-comparative approach allows for the option of incorporating data from several sources.

Ethical Considerations

This paper does not incorporate primary data from human subjects. Consequently, the potential to harm individuals is nonexistent. However, this paper does offer an opportunity to inform ongoing debates about health care around the globe.

COUNTRY CASE STUDIES

United States

The theoretical underpinnings of this paper indicate that political, labor, and medical institutions played a decisive role throughout the formative years of the US health care story. The cultural environment in which these various institutions operated was also important. What follows is an account of the events that took place during two major periods in US health policy history. These two time periods are of interest because they mark points where significant differences in the US and UK health care systems emerged. Relevant background information on political, labor, and medical institutions precedes this account.

Background. Unlike many other countries, the United States has a federal and decentralized system of government (Blank and Burau 2004). The US Constitution specifies three branches of government: executive, legislative, and judicial. Voters separately elect the president (leader of the executive branch) and the Congress (legislative branch). The Congress is composed of a Senate and a House of Representatives (Raffel and Raffel 1997). A member of Congress must introduce any proposed law in the Senate or House. On introduction, members refer the bill to an appropriate committee for study. The committee prepares a report on the bill, which it forwards to the full Senate or House. As part of this process, the committee has hearings, which provide an opportunity for interested individuals and/or parties to express their support or opposition to the bill. Many bills never make it out of committee. Ultimately, for a bill to become law, both houses of Congress must pass it, and the president must

sign it. If the president refuses to sign the bill, it can still become law with the approval of two-thirds of both houses of Congress (Raffel and Raffel 1994). The United States also has an independent and active judiciary, which sometimes takes part in resolving important issues. Structurally, state political institutions are similar to federal political institutions. To complicate the situation further, federal and state governments often find themselves at odds with each other (Raffel and Raffel 1997). Since legislative proposals require approval at many autonomous institutional layers if they are to become law, the system of government in the United States favors incremental change. Bold reforms, including proposals calling for universal health care, are unlikely to survive the lawmaking process. Even if they successfully traverse the lawmaking process, proposals may still be subject to constitutional scrutiny.

In terms of labor institutions, for much of the nineteenth century, American and British labor were similar in many respects. By the mid-1880s, however, the labor movements in the two countries were on different paths. American labor had become more radical than British labor. One late-nineteenth-century organization, the Knights of Labor, represented this shift in the US labor movement. The Knights of Labor was an inclusive and egalitarian organization. In contrast to other labor groups, the organization did not discriminate against workers of a particular skill level, nationality, race, or gender. Over a relatively short period of time, the organization's membership grew considerably. By 1886, the Knights of Labor had organized about 10 percent of the industrial labor force. This dramatic growth was short-lived (Fantasia and Voss 2004).

As the Knights of Labor expanded their influence and power, employers mobilized to stop them. As the government did little to constrain employers' actions in

the United States of the 1880s, the Knights of Labor was unable to survive. The organization's "social unionism" succumbed to its rival, a much more conservative "business unionism." In other words, the defeat of the Knights of Labor was a victory for those who supported a moderate, pragmatic unionism. Samuel Gompers, president of the American Federation of Labor (AFL), was among the supporters of this viewpoint (Fantasia and Voss 2004). According to Fantasia and Voss (2004:37-8), "...the AFL's version of unionism—narrow, craft-based, and sectional—became firmly institutionalized, making it that much more difficult for successive generations to imagine or to accomplish a broader industrial and general unionism that might venture to represent a wider social constituency." Given these developments, the US labor movement was not inclined to pursue universal health care.

With regard to medical institutions, the medical profession spent much of the nineteenth century struggling to become a voice of authority in matters related to health. Relying on their own common sense, many Americans simply refused to accept physicians as authoritative (Starr 1982). To combat this attitude of skepticism, some physicians "took...steps to reproduce in America the professional institutions that in England gave physicians a distinct and exclusive status" (Starr 1982:30). They established medical schools and medical societies. Through medical schools, these physicians hoped to elevate the medical profession. However, they were unable to stop other physicians from creating their own medical schools. The result was unrestricted competition among medical schools. Ultimately, to stay competitive, various medical schools shortened the length of terms, lowered their standards, and decreased fees (Starr 1982). "In seeking to raise their status individually, physicians undermined it

collectively” (Starr 1982:44). In addition, some physicians, particularly those who admired British professional institutions, wanted state legislatures to extend licensing authority to medical societies. After some early failures, these physicians met some success; several state legislatures granted some licensure powers to medical societies. These powers turned out to be very limited and totally ineffective (Starr 1982). “Neither [medical schools nor medical societies] held definitive authority, since it was possible to enter medical practice without the approval of one or the other, or both” (Starr 1982:45). The medical profession, then, was in complete disarray (Starr 1982).

Moreover, with concern that licensure was more about favoritism than competence abounding, many state legislatures rescinded licensing laws. Frustrated that the medical profession lacked a clear set of rules and regulations, several young physicians met to form a national medical association. This national group would soon become the AMA (Starr 1982). The AMA “aimed primarily to raise and standardize the requirements for medical degrees” (Starr 1982:90). It also established a code of professional ethics, which failed to acknowledge the legitimacy of certain kinds of physicians. For the first few decades of its existence, the AMA failed miserably in its endeavors, and divisions in the medical profession persisted. Toward the end of the nineteenth century, the AMA changed course. In an effort to unify and strengthen the medical profession, the AMA joined forces with its old adversaries. Working together, the AMA and its new allies were able to achieve the passage of several favorable licensing laws, an indication that the public was on its way to accepting the authority of the medical profession. In the early twentieth century, the AMA revised its constitution, creating a new representative body. Members of this new body would come mainly from

state medical societies. Eventually, under this new organizational structure, the AMA grew considerably (Starr 1982). As Starr (1982:110) notes, “From a mere eight thousand members in 1900, the AMA shot up to seventy thousand in 1910, half the physicians in the country...From this period dates the power of what came to be called ‘organized medicine.’” A large and authoritative organization, the AMA had the power to pursue its own interests independent of the state.

1900 to 1920. The ideal of universal access to health care surfaced at the beginning of the twentieth century. A growing recognition of the extent and impact of inadequate health care, especially among the working poor, was the primary reason for this development (Derickson 2005). According to Derickson (2005:1), “Progressive investigators disclosed a vicious cycle of poverty and sickness, a cycle too seldom broken by adequate and timely medical care.” Continuing in this vein, during and after World War I, several states established commissions to investigate health matters. However, the driving force behind the first major movement for health insurance in the United States was the American Association for Labor Legislation (AALL) (Terris 1999). In 1906, academic economists Richard Ely and Henry Farnam founded the AALL. Through labor legislation, the AALL aimed to protect American workers from the potential abuses of a capitalist system. AALL leaders believed that the state’s role in this process should be one of regulation not redistribution. Like many Progressives, AALL reformers thought that direct relief to individuals was a bad idea as it could lead to increased dependency. After a successful campaign for workmen’s compensation laws, the AALL turned its attention to the issue of health security (Hoffman 2001).

In 1915, the AALL unveiled its “Standard Bill,” model legislation for compulsory health insurance. Though it had severe limitations, the plan represented a step toward universalism (Derickson 2005). AALL leaders settled on a state-by-state strategy for health insurance because they feared that “the courts would impose constitutional constraints on the implementation of national legislation” (Hoffman 2001:28). By 1916, reformers had introduced the Standard Bill in the legislatures of several states (Funigiello 2005).

Initially, many labor unions, as well as the AMA, reacted favorably toward the model legislation (Funigiello 2005). In the context of World War I, however, support for the plan evaporated quickly (Hoffman 2001). According to Hoffman (2001:46), “As wartime sentiment gave rise to a hatred of anything German, the AALL’s campaign also suffered because of compulsory health insurance’s origins in Germany.” Similarly, after the 1917 Russian Revolution, “anti-German sentiment increasingly became conflated with...Bolshevism and domestic radicalism” (Hoffman 2001:66).

In an expression of this sentiment, the New York State Legislature dealt the Standard Bill a major blow in 1919. A Republican senator and a Democrat assemblyman introduced the New York version of the model legislation, the Davenport Bill. The State Senate passed the Bill. Yet, when the Bill reached the Assembly, Speaker Thaddeus Sweet, Chairman of the Rules Committee, would not allow a vote on it. Instead, the Speaker proceeded to denounce the Bill as “Bolshevistic.” In 1920, with the reintroduction of the Bill looming, the Speaker suddenly precipitated the removal of five Socialist assemblymen. Needless to say, the Bill died. Indeed, no state came as close as New York to enacting a version of the AALL plan (Terris 1999). Given the structure of

state political institutions, the failure of supporters to secure passage of the Standard Bill is hardly surprising. Essentially, at the height of its success, the model legislation was able to attain support at only one autonomous institutional layer in the legislature of a single state.

Aside from the opposition it faced within state political institutions, the Standard Bill encountered resistance inside the labor movement (Derickson 2005; Fox 1986; Gordon 2003; Hoffman 2001; Starr 1982). In particular, the AFL opposed the AALL's efforts to enact compulsory health insurance laws. Moreover, many considered AFL president Samuel Gompers the spokesman for all of labor. Gompers had a strong distaste for state involvement in workers' lives that stemmed from what he perceived to be a long history of government attacks (via the judiciary) on labor. Gompers felt that state-administered, compulsory health insurance would undermine trade union power. He argued that strong unions were the best way to achieve health security for workers. Gompers also felt that compulsory health insurance was a threat to workers' individual liberties as Americans (Hoffman 2001). According to Hoffman (2001:116), "The AFL leader's fierce reaction to the [AALL] proposal sprang from his strongly held conception of the 'independence' of the American worker. Government interference in any aspect of workers' lives was suspect, but in the case of medical care it represented a direct threat to the privacy of workers' home lives and even of their bodies." Gompers and his supporters, then, believed that state intrusion into health care would not only weaken unions, but create dependency (Hoffman 2001).

Despite the AFL leader's opposition to compulsory health insurance, the Standard Bill did gain some support within the labor movement (Fox 1986; Hoffman 2001).

Supporters of the model legislation included several state labor federations (e.g., New York State Federation of Labor), women-dominated trade unions (e.g., Women's Trade Union League), and industrial unions (e.g., United Mine Workers). Some supporters argued that a state-run health insurance system would benefit unorganized workers who did not have access to union benefits and/or the means to obtain private benefits. Other labor leaders believed that existing union benefits were inadequate, failing to provide for the needs of workers. Many supporters also liked the idea of compulsory wage deductions to pay for health insurance coverage, a central feature of the AALL proposal. Since workers would contribute to the plan's cost, they would in no way be the beneficiaries of a charitable program. Ultimately, the AFL view of the state was victorious in the fight over compulsory health insurance (Hoffman 2001). Essentially, then, a high level of labor movement fragmentation undermined reformers' efforts to secure passage of compulsory health insurance measures.

Medical institutions also challenged the Standard Bill. Specifically, the AMA initially supported the model legislation but later strongly opposed it (Fox 1986; Funigiello 2005; Gordon 2003; Starr 1982). In 1914, AALL reformers began drafting the Standard Bill. Having respect for professional authority, they sought to involve the medical profession in this process. Anticipating some physician resistance, AALL reformers were pleasantly surprised when they learned that prominent physicians were sympathetic to their cause and willing to help. Among these prominent physicians were some of the leaders of the AMA. Although the AALL and AMA were united in many respects, the two organizations came to disagree on the issue of physician remuneration (Starr 1982).

What is more, prior to 1920, local medical societies held most of the power in the AMA (Gordon 2003). “While [national] AMA leadership flirted with the idea of reform, state and local medical societies staked out what would become the profession’s stock positions, including a deep distrust of ‘contract’ practice and resistance to the intrusion of any third party in the patient-physician relationship” (Gordon 2003:212). Growing opposition from the medical profession made passage of the AALL proposal in state legislatures all that much more difficult. To compound the situation, with the entry of the United States into World War I, many physicians joined the service, and the AMA shut down its committee on social insurance. As a result of the war, anti-German sentiment increased. Opponents tied the Standard Bill to German social insurance, a program they argued was inconsistent with American values (Starr 1982). In short, having no restrictive ties to other entities, the AMA determined that it could best ensure professional autonomy without the state’s assistance. In fact, the organization considered the state a major threat more than a potential help. Therefore, the AMA ultimately opposed the model legislation.

In sum, state political institutions, as well as labor and medical institutions, played a significant role in the failure of AALL reformers to enact compulsory health insurance laws during the first part of the twentieth century. The cultural environment in which these institutions were embedded also had an impact. Though their goal was to gain passage of the Standard Bill in state legislatures all across the country, AALL reformers met success at only one autonomous institutional layer in a single state legislature (i.e., New York State Senate). In his effort to stop the legislation, Speaker Sweet of the New York State Assembly employed anti-Bolshevistic sentiment. Unable to agree on their

approach to health security, labor leaders ultimately succumbed to the AFL view of the state. In other words, a high level of labor movement fragmentation hindered reform efforts. In his charge against state-sponsored insurance, the AFL president relied on the rhetoric of individual rights. With no restrictive ties to other entities, the AMA concluded that it could best secure its interests in the absence of state intervention. Therefore, the AMA fought against the model legislation. In the framing of its arguments, the AMA contended that state intervention posed a threat to the patient-physician relationship. Institutions and culture, then, intertwined to derail compulsory health insurance measures.

1921 to 1950. After the failure of its compulsory health insurance campaign, the AALL directed its attention elsewhere. During the 1920s, the organization was mainly concerned with unemployment and old-age issues (Funigiello 2005). In other words, the movement for compulsory health insurance was dormant. Despite the movement's inactivity, the 1920s saw an increase in concern about medical costs. Although medical costs had been rising for some time, it was not until the third decade of the twentieth century that the middle class felt the impact. Put another way, the economic problems associated with medical care started to affect a much larger portion of the population than they had in previous years (Starr 1982).

Growing concern over the costs of medical care led to the formation of the Committee on the Costs of Medical Care (CCMC). Over a five-year period, the CCMC published more than twenty reports on medical care in the United States. In 1932, the CCMC released its final report (Starr 1982). The majority recommended group practice and prepaid insurance plans, but the Committee stopped short of calling for national

health insurance (Funigiello 2005). Alternatively, the majority supported a privately-funded health insurance system, insisting that this type of system would be “more palatable to a nation that prided itself on individual freedom and private enterprise” (Funigiello 2005:11). Though not a single legislative proposal accompanied the CCMC final report (Gordon 2003), the group’s research provided a basis for New Deal proposals that were to come (Funigiello 2005).

At around the same time the CCMC released its final report, a dramatic shift was taking place in the role of American government. As a result of the Great Depression, many Americans looked to the government for relief (Weeks and Berman 1985). These circumstances offered an opportunity for renewed efforts to achieve health coverage for Americans. However, with millions of Americans out of work, unemployment insurance and old-age benefits were the top priorities (Starr 1982). In the 1932 election, Democrat Franklin D. Roosevelt (FDR), who had called for active federal involvement to aid struggling Americans during his campaign, won the presidency, and Democrats ended up with large majorities in both houses of Congress (Reeves 2000). With a new Democrat administration soon to be in power, social reform seemed possible (Starr 1982). Given the number of autonomous institutional layers in the US political system, though, social reform, especially related to health care, would be difficult to accomplish.

In 1933, FDR took office. During his first term, he set up various agencies for the purpose of combating the difficult economic conditions of the time. In mid-1934, FDR appointed the Committee on Economic Security (CES) to investigate problems related to economic security and make legislative recommendations. By the end of that same year, the Committee had a report ready for the President (Weeks and Berman 1985). In its

report, the CES deferred any recommendation on health insurance, pending the completion of additional research on the subject (Derickson 2005). From this report came the Social Security Bill (Weeks and Berman 1985). While Congress took up the Bill, the CES finished its research. Since its inclusion would likely have prevented the Bill from gaining the necessary political support for passage, health insurance was not part of the final legislative package (Derickson 2005). In 1935, the Social Security Bill became law (Funigiello 2005). Even though the Social Security Act did not contain health insurance, critics complained that the law would lead to a loss of traditional American self-reliance (Reeves 2000).

In the late 1930s, the push for health insurance gained a second wind. In 1936, FDR appointed an Interdepartmental Committee on Health and Welfare Activities (ICHWA). The aim of the ICHWA was to oversee activities within the government related to health care. Assuming widespread support for some form of national health insurance, the Committee sought to add this type of coverage to the Social Security Act (Gordon 2003). In 1937, the ICHWA established a Technical Committee on Medical Care (TCMC). The TCMC was to investigate what role the federal government should play in the nation's health care. The ICHWA instructed the TCMC to draft recommendations for a national health program. In the process of constructing its report, the TCMC used data from the National Health Inventory (NHI), the most comprehensive research available on the nation's health care. The NHI revealed the inadequacies of the health care practices and procedures of the time. Upon completion of the TCMC report, FDR called for a national conference on health care (Funigiello 2005). In mid-1938, the national health conference convened. Initially, FDR's reaction to the conference was

enthusiastic. The President even thought that making national health insurance an issue in the 1938 election would be politically viable. It was not long, however, before he changed his mind. The 1938 election brought huge conservative gains. From this point forward, southern Democrats and Republicans formed an alliance, making health care reform extremely difficult. With the start of World War II, FDR turned his attention to foreign affairs. In 1939, Senator Robert Wagner of New York introduced a bill reflecting TCMC report recommendations (Starr 1982). He insisted that his bill would not infringe on states' rights (Funigiello 2005). Unable to garner either presidential or congressional support, the Wagner Bill died in committee (Shaefer and Sammons 2009). In other words, Wagner's proposal failed to gain support at even one autonomous institutional layer.

Despite this setback, Wagner and some of his colleagues continued to push for national health insurance. In 1943, Wagner, Senator James Murray of Montana, and Representative John Dingell of Michigan introduced a new bill to Congress (Starr 1982). This bill never made it out of committee (Shaefer and Sammons 2009). In 1944, as part of their effort to enact health legislation, representatives of several interest groups, including organized labor, met in Wagner's office to form what eventually became the Committee for the Nation's Health (CNH) (Starr 1982). This advocacy group coordinated lobbying activities in support of national health insurance. A year later, after FDR's sudden death, Harry Truman became president. An advocate of national health insurance, Truman was anxious to get to work. A month later, Wagner, Murray, and Dingell introduced another bill. This bill, as well as several other Wagner-Murray-Dingell proposals over the next few years, never made it out of committee (Shaefer and Sammons

2009). Stated another way, all of these bills lacked the support necessary to gain passage at even one autonomous institutional layer.

Moreover, the committee hearings on the Wagner-Murray-Dingell bills reflected the post-World War II cultural debate taking place in the larger society. For example, in a 1946 Education and Labor Committee meeting, Senator Murray began the proceedings with an exhortation to witnesses to refrain from using terms like “socialistic” or “communistic.” Senator Robert Taft of Ohio, the ranking minority member of the Committee, interrupted Murray immediately. Taft argued that the bill under consideration was the most socialistic measure that had ever come before Congress (Funigiello 2005). As Funigiello (2005:68) states, “Taft charged that the national health bill came straight out of the Soviet constitution.” Banging his gavel, Murray tried to stop Taft from speaking, but Taft continued. Murray refused to yield, which prompted Taft to leave the room. After announcing a boycott of the Committee’s meetings, Taft left little doubt that the Wagner-Murray-Dingell Bill at issue would fail to advance. Though Murray said he would reintroduce the Bill later in the year, he was unable to do so as Republicans won majorities in both houses of Congress in the 1946 election (Funigiello 2005).

This development crushed the prospects for health care reform (Shaefer and Sammons 2009). For the remainder of the decade, Republicans continued to assert that national health insurance was a step toward socialism. Despite these circumstances, Truman campaigned on national health insurance in the 1948 election (Starr 1982). Truman won the presidency, and Democrats regained control of Congress. Truman again attempted to pass legislation (Shaefer and Sammons 2009). Facing opposition from Republicans, as well as southern Democrats who were unhappy with his civil rights

initiatives, Truman again met failure, as the proposed legislation died in committee (Funigiello 2005). In other words, the legislation did not have enough support to ensure passage at even one autonomous institutional layer.

Between 1921 and 1950, though unable to pass health insurance legislation, federal lawmakers did manage to enact several proposals that impacted the campaign for national health insurance. Much of this legislation dealt with labor issues (e.g., 1947 Taft-Hartley Act) (Gordon 2003). The Supreme Court also played a role in the campaign for national health insurance in that it handed down rulings that affected labor (e.g., *Inland Steel* case) (Gordon 2003; Shaefer and Sammons 2009; Starr 1982). Political institutions, then, had an impact on the ways in which labor institutions shaped health policy during this time period.

After the passage of the Social Security Act, the labor movement reentered the health policy arena. Much had changed since the fight over the AALL proposal in the 1910s. Gompers, who had been an ardent opponent of the Standard Bill, was no longer AFL president. Moreover, the Great Depression had left millions of wage earners impoverished and union benefit plans devastated. As a result of these conditions, the AFL dropped its longstanding support of voluntarism (Derickson 2005). The same year the Social Security Act became law, another important piece of legislation made its way through Congress and reached the President's desk (Starr 1982). The Wagner Act "limited the tactics employers could use in resisting unions, set up procedures for elections, and required management to bargain with unions that won the right to represent their workers" (Starr 1982:311). The National Labor Relations Board (NLRB) had the responsibility of enforcing this legislation. The Wagner Act revitalized the labor

movement, prompting the formation of the Congress of Industrial Organizations (CIO). Unions increased in size and influence (Reeves 2000). However, from 1935 to 1937, health benefits were not the primary concern for the labor movement. Rather, the newly established CIO was focused on the constitutionality of the Wagner Act. Indeed, the law was unclear as to whether or not health benefits were subject to collective bargaining. While both the AFL and CIO favored national health insurance, they also believed that collective bargaining had the potential to strengthen unions. Moreover, though they were unsure what the Wagner Act required of them, employers began to offer health plans to their employees, partly the result of union pressure and the possibility of federal legislation. The development of group health coverage, starting with Blue Cross, made this scenario feasible (Gordon 2003).

The story of Blue Cross begins in Dallas, Texas. In 1929, around the beginning of the Great Depression, Baylor University Hospital agreed to provide over a thousand school teachers a few weeks of hospital care a year for \$6 per person. Over time, the hospital entered into similar arrangements with several other groups. Other hospitals started comparable programs, which led to competition between hospitals for patients (Starr 1982). Both unions and employers found group health coverage an attractive option (Gordon 2003).

With the proliferation of private insurance underway, Congress began the debate over the 1939 Wagner Bill. Although at odds in some respects, the AFL and CIO were unified in their support of the Bill (Funigiello 2005). These two organizations also supported the various national health insurance proposals of the 1940s (i.e., the Wagner-Murray-Dingell bills) (Maioni 1997). Indeed, the AFL and CIO had a voice when it came

to the content of proposals during this time period (Weeks and Berman 1985). In fact, the 1940s saw the formalization of the relationship between labor and the Democratic Party. This relationship was rooted in the New Deal legislation of the 1930s. By the end of the 1940s, labor had devoted all of its political energies to the Democratic Party but had been unable to achieve national health insurance. The Democratic Party's southern foundation was at least partly responsible for this outcome (Gordon 2003).

Additionally, during and after World War II, a number of factors spurred the growth of private health insurance. A wartime wage freeze prompted employers to offer health benefits as a way to compete for workers. The 1942 Revenue Act allowed employers to deduct health insurance costs from their taxable earnings. Similarly, a 1943 National War Labor Board ruling accorded favorable tax treatment to employers and workers participating in employer-based coverage schemes. The ruling also permitted labor to bargain for health benefits in lieu of wage increases. Because it greatly restricted union power, the 1947 Taft-Hartley Act further encouraged labor to pursue worker benefits, as opposed to a national health insurance program. This act, however, was unclear as to whether or not health benefits were subject to collective bargaining. A 1948 NLRB ruling cleared up the matter, affirming that health benefits were indeed on the bargaining table. That same year, the Supreme Court upheld this NLRB ruling (Shaefer and Sammons 2009). Moreover, in order to diminish the appeal of union membership, many nonunion employers offered health benefits to their employees (Derickson 2005).

Under these circumstances, private health insurance significantly expanded (Gordon 2003). As Gordon (2003:21) states, "In 1935 hospitalization, surgical, and medical insurance each covered about two million persons; by 1950 hospital insurance

reached fifty-five million, surgical insurance reached thirty-nine million, and medical insurance reached seventeen million.” This growth in private health insurance coverage greatly undermined reform efforts (Shaefer and Sammons 2009). With little hope of achieving reform, some unions even made the case for private health insurance options. A number of labor leaders argued that, in the absence of adequate government programs, unions had a responsibility to meet the need of workers’ security through collective bargaining (Gordon 2003). By the end of the 1940s, labor as a whole was far less active in its support of a national health insurance program (Shaefer and Sammons 2009). In brief, though it was originally behind reform efforts, the labor movement lacked the resources necessary to enact proposed legislation. After experiencing several setbacks, many unions turned to collective bargaining to meet the need of workers’ security. In other words, a high level of labor movement fragmentation ultimately resulted in the dramatic growth of the private insurance industry.

Medical institutions, on the other hand, were largely successful in exerting their political will. Upon the release of the 1932 CCMC final report, the AMA attacked the majority position (Starr 1982). The AMA vehemently opposed the report’s two key recommendations: group practice and prepaid insurance plans. The AMA believed that the majority’s recommendations were the product of socialism and/or communism (Funigiello 2005). According to Funigiello (2005:11), “The AMA...responded to the majority’s recommendations by accusing the group of subverting American values and by reaffirming the sanctity of private practitioner fee-for-service medicine.” Partly the result of the AMA’s reaction to the majority position, upon taking office, FDR was hesitant to tackle the issue of health security (Starr 1982). Fearing that the AMA and its

congressional allies would kill the entire 1935 Social Security Act, the administration decided to exclude national health insurance from the legislative package (Funigiello 2005). Similarly, the AMA strongly opposed the 1939 Wagner Bill. Though Wagner argued that his proposal was consistent in many respects with the AMA's most recent position on health security, the AMA ultimately testified against the legislation (Starr 1982). The AMA believed that the Wagner Bill would eventually lead to compulsory health insurance, which was code for "socialized medicine." Continuing in this vein, the AMA opposed the national health insurance measures of the 1940s. The organization also had at its disposal the resources necessary to kill reform efforts (Funigiello 2005).

For example, after Truman won the 1948 election, the AMA increased the amount of its membership fee. With the added funds, the AMA intensified its resistance to a national health insurance program. As part of its campaign, the AMA hired Whitaker and Baxter, a public relations firm. The AMA made \$1.5 million available to the firm to spend against health reform efforts (Starr 1982). According to Starr (1982:285), "Whitaker and Baxter used pamphlets, the press, public speakers, and private contacts to stress that voluntarism was the American way and to persuade private organizations...to endorse the AMA position." The efforts of the AMA in conjunction with Whitaker and Baxter were so successful that many supporters of health reform referred to national health insurance legislation as "socialized medicine" (Starr 1982).

In contrast, the CNH, an advocacy group that represented organized labor and other proponents of a national health insurance program, had limited financial resources (Funigiello 2005). As Funigiello (2005:81) states, "Outspent, CNH was reduced to mailing each member of Congress a fact sheet—and hoped that it would be read!" In

short, having no restrictive ties to other entities, the AMA had many degrees of freedom to pursue its own objectives. Hence, the organization opposed state intervention in health care. Moreover, since it viewed state intervention as a threat to professional autonomy, the AMA used its financial resources to recruit allies. Having power superior to that of advocacy groups, the organization met some success as it strived to stop reform efforts.

To summarize, from 1921 to 1950, political, labor, and medical institutions all played a significant role in the persistent defeat of health legislation. Moreover, anti-statist rhetoric dominated the health care debate. At various autonomous institutional layers, politicians failed to give their support in numbers sufficient to secure passage of health insurance legislation. During lawmaking processes, opponents frequently characterized reform efforts as “socialistic” and/or “communistic.” Labor unions, though initially unified in their support of national health insurance, eventually turned to collective bargaining to serve the need of workers’ security. As they generally supported reform efforts, unions had little incentive to employ anti-statist rhetoric. With no restrictive ties to other entities, the AMA had the option of pursuing its objectives free from state intervention. As such, the organization rejected the notion of national health insurance. In the framing of its arguments, the AMA regularly made references to “socialized medicine.” Institutions and culture, then, worked together to stop national health insurance from becoming a reality.

United Kingdom

Clearly, political, labor, and medical institutions played a decisive role throughout the formative years of the US health care story. The cultural environment in which these

institutions operated was also important. The same is true for the United Kingdom. Why, then, did the United States and the United Kingdom take such different paths on health care? Simply put, the political, labor, and medical institutions in the two countries had contrasting features. The United States and the United Kingdom also had distinct cultural environments in which these various institutions were embedded. What follows is an account of the events that transpired during two major periods of the UK health care story. This account comes after important background information on political, labor, and medical institutions.

Background. In terms of political institutions, the United Kingdom has a unitary and centralized system of government (Blank and Burau 2004). In addition to being a parliamentary democracy, the United Kingdom is a constitutional monarchy with a royal head of state. The prime minister exercises executive authority. To aid in carrying out executive responsibilities, the prime minister appoints a cabinet from members of the legislature. The legislature, Parliament, is composed of the House of Lords (upper house) and the House of Commons (lower house). To become law, legislative proposals require the approval of both houses and royal assent (Hatcher 1997). As a result of legislation that gained passage in August 1911, however, the House of Lords lost veto power (Packer 1998). Currently, the upper house can only delay, not prevent, the passage of proposed laws. Moreover, in the context of lawmaking, royal assent is a constitutional formality. Voters elect one central government: Parliament. To remain in power, the prime minister must control a majority of the seats in the House of Commons. Therefore, the distinction between executive and legislative power is basically non-existent (Hatcher 1997). Additionally, in the United Kingdom, a high court cannot challenge or override

Parliament (Blank and Burau 2004). Similarly, the central government does not share powers with sub-national governments (Hatcher 1997). Since legislative proposals require approval at only one autonomous institutional layer (i.e., the House of Commons) if they are to become law, the UK system of government is more inclined to produce any kind of change (non-incremental or incremental) than is the US system of government. Equally important is the fact that legislative proposals in the United Kingdom do not have to endure constitutional scrutiny in the same way they do in the United States.

With regard to labor institutions, during the nineteenth century, to avoid the financial hardship that illness might bring, many workers created mutual aid groups called friendly societies. For a weekly contribution, these organizations provided sick pay, medical care, and a death benefit for their members. Friendly societies and physicians entered into agreements, which usually required physicians, in return for a fixed salary, to give medical care to society members (Goodman 1980). According to Jacobs (1993:44), “Through a vast network of local and national branches that stretched across Britain, Friendly Societies came to encompass 4.5 million of the most respected portion of the working class by the organization’s peak in the late 1800s.” As they grew larger, many friendly societies struggled financially. Despite this fact, these organizations held a great deal of political power (Goodman 1980). This being the case, they were more inclined to pursue legislation at the national level than their counterparts in the United States.

As for medical institutions, in the United Kingdom, medicine’s pursuit of professional authority began during the sixteenth century. In 1518, a small, elite group of physicians were able to secure the charter for the Royal College of Physicians (Moran

1999). Throughout the next few centuries, other groups successfully established medical societies that were able to gain control over licensing procedures and/or educational standards (Levitt, Wall, and Appleby 1999). For example, the 1815 Apothecaries Act “gave the Society of Apothecaries the right to license those who had served a 5-year apprenticeship and passed examinations...” (Levitt et al. 1999:164). Despite the successes of medical societies, unqualified physicians thrived (Levitt et al. 1999). Hence, the “demand arose for a single licensing authority and a single professional qualification permitting practice in any branch of the profession” (Levitt et al. 1999:164). At the forefront of this drive for centralized control was the Provincial Medical and Surgical Association. This organization would soon change its name to the British Medical Association (BMA). The end result of the campaign was the passage of the 1858 Medical Act (Levitt et al. 1999). The Act firmly institutionalized what constituted a qualified physician (Moran 1999).

Moreover, during the nineteenth century, many physicians both worked with friendly societies and operated their own private practices. With membership in working-class organizations growing, an ever increasing number of physicians entered into agreements with friendly societies and/or other labor groups. Some physicians came to rely on society income for their subsistence. By the mid-1800s, many physicians had become dissatisfied with these arrangements. Hence, they made sporadic attempts to reform the system. Ultimately, they failed in these endeavors. Around the turn of the twentieth century, the BMA joined the struggle for reform. At the national level, the organization made every effort to rectify the situation. Unable to secure appreciable reform, the BMA eventually concluded that government intervention was a viable option

(Honigsbaum 1990). The BMA, then, did not have the power to pursue its own interests independent of the state. Of course, the circumstances under which the AMA operated were much different.

1900 to 1911. According to Sakala (1990:718), “War...provided an important impetus for the U.K. to move away from reliance on the Poor Law system, established in 1601, and toward a national medical care program.” During the Boer War (1899-1902), many recruits were found unfit to serve (Sakala 1990). Public outrage led to the 1907 School Medical Service Act, “the first major piece of public medical legislation providing personal medical services outside the jurisdiction of the Poor Law...” (Sakala 1990:718). Also of significance were the majority and minority reports of the Royal Commission on the Poor Laws and Relief of Distress. These two reports offered a critique of the poor-law system (Sakala 1990). It was not until 1911, however, that some form of national health insurance became law. David Lloyd George, Chancellor of the Exchequer under the Liberal government, was largely responsible for this outcome (Goodman 1980).

In 1908, with the resignation of Prime Minister Henry Campbell-Bannerman, a cabinet reshuffle became unavoidable. When Herbert Asquith left his post of Chancellor to become the next prime minister, Lloyd George filled the vacancy. Continuing the work of his predecessor, Lloyd George took on the issue of old-age pensions (Packer 1998). After the passage of the 1908 Old Age Pensions Act, Lloyd George turned his attention to the issues of unemployment and invalidity. To study these issues, Lloyd George visited Germany, a country with a national insurance scheme already in place (Grigg 1978). According to Grigg (1978:314), “He returned favouring, for these problems, the method

of contributory insurance which had not been applied in the old age pensions scheme.”

Concerned with sickness as a cause of poverty, Lloyd George eventually proposed a plan that would provide medical care for some workers. To make his plan viable, he had to build support. Through skillful negotiation and compromise, Lloyd George was able to accomplish this goal (Goodman 1980).

To aid in the process of making national insurance a reality, Lloyd George brought together a group of colleagues to discuss the matter. One point of debate was whether or not British national insurance should operate on the dividing-out principle or the accumulation principle. While Lloyd George preferred the former, one of his colleagues, William Braithwaite, supported the latter. Since he needed the cooperation of those who espoused the accumulation principle, Lloyd George eventually succumbed to Braithwaite’s point of view (Grigg 1978). As Grigg (1978:324) states, “To the Tories, and indeed to many Liberals, the dividing-out principle was suspect, whereas accumulation seemed responsible and sound. Since...[Lloyd George’s] aim was to win conservative endorsement of a radical measure, he felt obliged to accept a method of insurance which his private judgment rejected....” In addition to this concession, Lloyd George made a special effort to be friendly toward his opponents. In time, his proposal was ready for submission to the cabinet. Shortly thereafter, the cabinet gave the proposal its approval. A month later, Lloyd George introduced his scheme in the House of Commons. After a series of debates and the adoption of several amendments, Parliament passed the measure. Although it varied in significant ways from Lloyd George’s original plan, the National Insurance Act became law in December 1911 (Grigg 1978). In short,

with only one autonomous institutional layer with which to contend, a shrewd politician was able to make national health insurance a reality in the United Kingdom.

In addition to political institutions, labor institutions were instrumental in shaping health policy during the 1910s. To achieve passage of the 1911 National Insurance Act, Lloyd George sought the support of working-class organizations, particularly friendly societies (Goodman 1980). According to Gilbert (1965:128), “The societies had...a reputation for great parliamentary influence. No government could ignore them, a Liberal administration threatened by a growing Labour party least of all.” Although they had political clout, many friendly societies were in serious financial trouble (Grigg 1978). As Grigg (1978:317) states, “More and more of their members were living on into old age, while the declining birth-rate was a blow to recruitment. There were too many societies chasing too few potential members and finding their actual members an increasing burden.” Despite these circumstances, friendly societies’ general reaction to Lloyd George’s proposal was one of suspicion (Grigg 1978). Concerned that the government might become too involved in their activities, many friendly societies were hesitant to give Lloyd George’s plan their support. However, Lloyd George was able to convince these friendly societies that he intended to work through them, not eliminate them (Goodman 1980). He assured them that his plan would “make State insurance compulsory for all working men who could not be better provided for by friendly societies, but in no way to compete with the societies” (Grigg 1978:317). The scheme, then, would target a specific segment of the population, as well as provide a sickness, disability, and widowhood benefit. Friendly societies would offer different benefits,

including a payment on death. Lloyd George also agreed to allow friendly societies, in the form of “approved societies,” to administer the plan (Gilbert 1965).

To complicate matters for both Lloyd George and friendly societies, a group known as the “Combine” entered the debate. The group was composed of several industrial insurance companies and collecting societies (Gilbert 1965). The Prudential was perhaps the most important of these companies (Grigg 1978). According to Gilbert (1965:129), “The Prudential was the nation’s largest holder of railroad securities, the largest private owner of ground rents and freehold properties, the largest holder of Bank of England stocks, the greatest source of the local authority borrowing, and nearly the largest owner of colonial and Indian government bonds.” The Prudential and its allies, then, formed a powerful industrial insurance lobby. The chief representative of the Combine was Howard Kingsley Wood. In general, industrial insurance policies provided only a funeral benefit. The Combine feared that the inclusion of a widowhood benefit in Lloyd George’s plan would be detrimental to business (Grigg 1978). As a widowhood benefit would be due to the widow upon the death of the breadwinner, the Combine believed that this type of benefit would be indistinguishable from a funeral benefit. Under tremendous pressure from the Combine, Lloyd George dropped the widowhood benefit from the scheme (Gilbert 1965).

Eventually, at the prompting of Kingsley Wood, the Combine asked to join the scheme. The group sought the same approved status that Lloyd George had granted to friendly societies (Grigg 1978). “In case the Government in the future decided to offer some form of death benefits, the companies felt they would be better able to protect their existing business as administrators on the inside of the health program” (Gilbert

1965:139). Many friendly societies strongly objected to this idea. Later, the Combine intensified its efforts to gain approved status. The group worried that friendly societies would use the government program to monopolize the funeral benefit industry. Unhappy with friendly societies, the BMA threw its political weight behind the companies and collecting societies. To the dismay of many friendly societies, the Combine obtained approved status (Gilbert 1965).

As Braithwaite and others believed that the scheme would be impossible to work without the support of friendly societies, Lloyd George found himself in a situation where his rhetorical skills might be of some use (Gilbert 1965). At some point during the conflict between the Combine and friendly societies, he also offered friendly societies what amounted to a massive subsidy to society reserves. Since they were financially struggling, many friendly societies could not turn away from an opportunity to greatly increase their funds (Grigg 1978). As Grigg (1978:325) states, "Lloyd George thus gained the qualified support of the 'Combine' without losing that of the friendly societies, and without altering his scheme out of recognition." In short, though the Combine complicated matters, friendly societies on the whole remained committed to the passage of Lloyd George's national health insurance proposal.

Lloyd George also sought the support of medical institutions. The BMA opposed Lloyd George's original plan. The organization was concerned that the plan would give too much control to friendly societies. For a long time, physicians had been unhappy with the extent to which friendly societies exercised power over the provision of medical care. To mollify physicians, Lloyd George gave control of medical benefits to the public sector (Starr 1982). As Starr (1982:256) notes, "Thus the shift of medical care into the public

sector in Britain arose partly because of the doctors' desire to liberate themselves from a form of client control." In other words, physicians were willing to accept government intervention if it meant getting out from under the thumb of friendly societies (Starr 1982). The medical profession also opposed Lloyd George's original plan because of the issue of remuneration. Physicians worked for incomes that were already relatively modest, and they feared that the plan would make matters worse. With the threat of a physician boycott looming, Lloyd George increased the minimum capitation fee physicians would receive under the plan (Goodman 1980). Despite these concessions, the BMA called a strike against the government. However, BMA opposition diminished as physicians realized they could make more money if they worked under Lloyd George's scheme (Starr 1982). In short, the BMA lacked the power to pursue its own interests independent of the state. Bound by restrictive ties to other entities, the organization was open to government involvement in health care.

Similar to the situation in the United States, political, labor, and medical institutions all played a vital role in shaping UK health policy during the first part of the twentieth century. The cultural environment in which these institutions operated was also important. However, contrasting institutional and cultural realities produced divergent outcomes in the two countries. Success at only one autonomous institutional layer spelled defeat for reformers in the United States, whereas a similar feat resulted in the implementation of a national health insurance program in the United Kingdom. Moreover, noticeably absent from the health policy discussion in the United Kingdom was the anti-statist rhetoric characteristic of the debate in the United States. While the AFL view of the state prevailed over alternative perspectives in the United States, a sense

of unity in support of a national health insurance program was prevalent among friendly societies in the United Kingdom. Some friendly societies expressed concern over the potential for state involvement in health care, but the AFL and its allies were explicitly anti-statist in their approach. With no restrictive ties to other entities, the AMA determined that it could best secure its interests in the absence of state intervention. In contrast, with limited power to independently pursue its own interests, the BMA concluded that state intervention was a viable option. Additionally, unlike its counterpart in the United Kingdom, the AMA exuded an anti-statist attitude. Variations in institutional and cultural realities, then, contributed to distinct policy outcomes in the two countries.

1912 to 1950. The next major debate over health policy in the United Kingdom culminated in the passage of the 1946 National Health Service Act. Though it represented a significant step toward more government involvement in the provision of medical care, the 1911 National Insurance Act had limitations. The Act covered some workers but not their families. Moreover, the Act was concerned only with the provision of general practitioner (GP) services not hospital care (Ham 1999). As such, the indigent largely continued to rely on the poor-law system for relief, and much of the working class gained access to hospital care through private insurance (Goodman 1980).

Over time, many Britons became dissatisfied with these arrangements. Working under the Lloyd George scheme, some physicians complained that their incomes were not increasing at the same pace as consumer prices. They also objected to the fact that the plan offered little incentive for them to maintain a high quality of care. However, since treatment was “free” at the time of service, patients had incentive to demand much from

physicians. To complicate the situation further, many Britons were frustrated that inequalities persisted under the plan. Some approved societies provided better services than others. Likewise, a common belief was that private insurance was superior to public insurance (Goodman 1980).

Moreover, as Sakala (1990:718) states, “The British experience with military medicine in the First World War helped create a consensus among doctors that medicine should be rationally organized.” Together with the 1918 influenza pandemic, this consensus led to the formation of the Ministry of Health (Sakala 1990). As Hardy (2001:77) states, “The establishment of the new Ministry of Health...promised integrated, health-oriented policies at national level.” To accomplish these goals, the Ministry appointed the Consultative Council on Medical and Allied Services to provide some direction on health policy. The group’s chair was Lord Bertrand Dawson (Sakala 1990). Ultimately, the Dawson Report endorsed the idea of a “comprehensive scheme of hospital and primary health care” (Ham 1999:10). Later reports also offered suggestions for change. The Royal Commission on National Health Insurance issued a report in 1926, and the BMA released a report in 1930 and 1938 (Ham 1999). Indeed, strong sentiment in favor of change was abounding.

Operating within a unitary and centralized system of government, legislators passed the 1929 Local Government Act. The Act gave local authorities the power to convert old poor-law institutions into municipal hospitals (Honigsbaum 1990). During the 1930s, however, major health care reform was not the primary concern in government deliberations. Rather, the economy and foreign policy were the dominant issues of the decade. This being the case, Ministry of Health officials pursued only a couple of

incremental reforms. Eventually, they concluded that it was impractical to attempt even minor changes. Though they agreed that the status quo was unacceptable, Ministry of Health officials recognized that they would likely encounter fierce opposition from various interest groups. They also believed that the general political climate presented practical difficulties they would probably not be able to overcome (Jacobs 1993). The Conservative Party had become associated with “economic recovery and prudence,” while the Labour Party had lost credibility due to its past failures (Jacobs 1993:65).

Prior to World War I, the early Labour Party had put its political weight behind the Liberal Party (Skocpol 1992). However, the war created new opportunities for the Labour Party to expand its power. Trade unions’ influence increased within a national wartime labor market, and the Liberal Party split (Morgan 1984). “All this enabled Labour to emerge unambiguously after the war as the decisive voice of the British left” (Morgan 1984:10). The franchise reform of 1918 reinforced this new role for the Labour Party. Enfranchising millions of working-class voters, this reform created a democratic impetus for a class-based political party (Morgan 1984). After a few short years, though, the Labour Party was in disarray (Jacobs 1993). As Jacobs (1993:70) states, “During the interwar period, the Liberal party continued its slide into obscurity, and the governments formed by Labour in 1924 and 1929-31 were political disasters, discrediting that Party and throwing the entire organized labor movement into retreat.” Political and labor institutions, then, were inextricably tied to each other.

This trend continued into the 1940s. At the onset of World War II, the Conservative Party controlled the government. However, it soon entered into an agreement with its opposition, especially the Labour Party. Conservatives brought Labour

into the government as an equal partner. In return, Labour agreed to support Conservatives' conduct of the war. Labour became a powerful force in domestic affairs. Wartime experiences encouraged support for expanded government involvement in health matters. In response to this sentiment, Labour wanted to make a commitment to postwar social reform. Conservatives, on the other hand, objected to this idea. The two parties were able to compromise: the government would simply study the issue of postwar reform (Jacobs 1993). "Although the Conservatives viewed this process as a means for limiting policy discussion and restraining public expectations, it ultimately encouraged policymakers and the public to expect major postwar reforms" (Jacobs 1993:72). This movement toward policy investigation led to the formation of several committees, including William Beveridge's committee (Jacobs 1993).

In 1942, Beveridge's committee published its report. In short, the Beveridge Report called for a compulsory social insurance program, with comprehensive, "cradle to grave" coverage (Morgan 1984). More specifically, the Report made three major recommendations: a new health service, a children's allowance program, and a full employment plan. In addition, Beveridge's proposal contended that benefits should be universally available (Jacobs 1993). The Report was enormously popular and "became the foundation of all detailed social planning and policy-making for the post-war world" (Morgan 1984:21). Though they had points of disagreement, partners in the coalition government came to accept Beveridge's proposal (Jacobs 1993). Then, in 1944, the coalition issued a White Paper that recommended a compulsory health insurance program. Under the plan, coverage would extend to the entire population (Goodman 1980). The following year, Labour was victorious in the general election (Morgan 1984).

These developments set the stage for the passage of the 1946 National Health Service Act.

No longer a partner in a coalition government, Labour departed from previous discussions and arrangements on health policy in two major ways. First, Labour formulated bold new ideas (e.g., nationalization of hospitals). Second, Labour introduced proposals to Parliament, which the coalition government had failed to do. To ensure significant control over the health reform process, Prime Minister Clement Attlee reorganized the cabinet. As a result of this restructuring, Attlee and the cabinet greatly influenced the development of legislation. Minister of Health Aneurin Bevan produced a proposal. Shortly thereafter, the cabinet began considering Bevan's plan. Various ministers disagreed on specific features of the plan, especially the issue of nationalizing hospitals. They asked Bevan to provide more detailed information (Jacobs 1993).

Eventually, though points of contention remained, the cabinet accepted the core components of Bevan's proposal and authorized the drafting of a bill. Labor representatives in the House of Commons strongly supported these actions. Ultimately, the cabinet introduced the bill to Parliament (Jacobs 1993). As Jacobs (1993:174) states, "With the important battles fought within the government's revamped policy making structure, the cabinet's bill was overwhelmingly carried in Parliament with no significant alterations; it was signed into law in November 1946." In addition to reorganizing its internal policymaking process, the Labour government was able to achieve this feat because it had restricted interest group participation in the formulation of legislation. The cabinet had endorsed Bevan's position that, in a democratic system, elected officials should make decisions about the main features of proposals (Jacobs 1993). In brief, with

only one autonomous institutional layer with which to contend, reformers were able to gain enough support to ensure legislative success. Moreover, the Labour Party was unified and persistent in its efforts to achieve health care reform. Political and labor institutions, then, were instrumental in the passage of the 1946 National Health Service Act.

Medical institutions were also important. A result of the 1911 National Insurance Act, the medical profession was tied to the state. The expansion and coordination of state-sponsored health activity was, therefore, an appealing option (Sakala 1990). In its 1942 report, the BMA recommended “nothing less than a centrally planned public medical service under government control” (Goodman 1980:13). Despite this fact, the organization was worried when the Labour Party won the 1945 election. Most physicians were not opposed to national involvement in health matters. They were, however, concerned about *excessive* government control (Goodman 1980).

To gain the support of the medical profession, Bevan made many concessions to both consultants (specialists) and GPs. For example, he agreed to allow consultants to maintain their private practices. Under the new system, consultants would be able to treat private patients in government hospitals (Morgan 1984). Bevan also agreed to permit GPs to practice as “independent contractors.” In other words, they would not be salaried employees of the state (Goodman 1980). (The BMA doubted Bevan’s sincerity on this point.) Though Bevan granted these concessions, the BMA still objected to the plan. In a 1946 BMA ballot, GPs voted against participation in the new health service by a huge margin. A 1948 BMA ballot had a similar result. Without the support of the nation’s physicians, Bevan was concerned that the service would be shackled from the start. A

few months before the launch of the service, Bevan delivered a precise statement addressing physicians' concerns (Morgan 1984). He "affirmed that no whole-time salaried service would be introduced by regulation" (Morgan 1984:160). With support for the service growing among GPs, the BMA reluctantly recommended that its members drop their opposition (Goodman 1980). In short, as it was already tied to the state, the organization ultimately determined that opposition to the scheme was contrary to its own interests.

As was the case in the United States from 1921 to 1950, political, labor, and medical institutions were all instrumental in determining UK health policy from 1912 to 1950. Also crucial was the cultural environment in which these institutions were embedded. Yet, the two countries ended up with different results, as distinct institutional and cultural realities produced contrasting outcomes. Success at one autonomous institutional layer in the United Kingdom resulted in the passage of a universal health care program. A similar achievement in the United States would not have been adequate. Moreover, unlike their counterparts in the United Kingdom, opponents in the United States often engaged in anti-statist rhetoric during the lawmaking process. Though initially unified in their support of a national health insurance program, US labor unions eventually turned to collective bargaining to serve the need of workers' security. In contrast, the Labour Party in the United Kingdom was unified and committed to the passage of a national health insurance program. As supporters of a national health insurance program, neither the US labor unions nor the UK labor party had much use for anti-statist language. With no restrictive ties to other entities, the AMA was in a position to achieve its own ends without the state's help. Alternatively, the BMA was closely tied

to the state and was somewhat limited in its options because of this relationship.

Additionally, unlike its counterpart in the United Kingdom, the AMA frequently used anti-statist rhetoric in the framing of its arguments. Variations in institutional and cultural realities, then, contributed to contrasting policy outcomes in the two countries.

CONCLUSION

The primary question at issue in this paper is the following: given the similarities between the two countries with regard to welfare state institutions, why have the United States and the United Kingdom diverged on the issue of health care? Drawing on the new institutionalist paradigm, and particularly on sociological institutionalism, this paper provides an answer to this question: during the formative years of the health care stories in the two countries, variations in institutional and cultural conditions produced contrasting policy outcomes. More specifically, this paper shows the ways in which political, labor, and medical institutions impacted the fate of certain policy proposals in the United States and the United Kingdom. What is more, this paper demonstrates the role that culture played in these processes. In short, the data provide support for this paper's four propositions.

These results make evident the value of an approach that utilizes the principles of sociological institutionalism. A meso-level perspective, sociological institutionalism contrasts sharply with other viewpoints. For example, drawing on the macro-level theorist Karl Marx, some scholars opt for a class-based approach. These scholars examine the ways in which class-based political struggles shape the welfare state (e.g., Korpi 1978). The results here demonstrate the inadequacy of a perspective that concentrates solely on working-class strength. For instance, the data show that medical institutions were central to policy outcomes. Other scholars take a meso-level approach that deals with institutions; however, these scholars focus mainly on political institutions, or in other words, the state (e.g., Orloff and Skocpol 1984). Again, the results here

demonstrate the limits of such a perspective in that both state and non-state institutions were instrumental to policy outcomes.

Of course, this paper's results have implications for current policy debates. With an increased understanding of the role that institutions and culture play in policy outcomes, important stakeholders may be in an improved position to assess the range of legislative possibilities. Similarly, they may be better able to discern the extent to which existing institutional arrangements can effectively accommodate potential changes. These points apply to both health policy, as well as to other types of policy. For example, scholars may find it worthwhile to apply sociological institutionalism to tax policy or energy policy. Naturally, in such studies, the relevant institutions may differ from the ones this paper highlights. Surely, then, sociological institutionalism is a significant asset to scholars working in a variety of fields. An exploration of the ways in which the other branches of the new institutionalist paradigm (i.e., historical institutionalism and rational choice institutionalism) or other institutional theories are applicable to an array of subjects may also be insightful.

Certainly, this paper makes a valuable contribution to several areas of scholarship, including the following: health studies, institutional theory, policy studies, and comparative welfare state studies. That said, this paper has limitations. For instance, while it addresses the issue of culture, this paper does not really explain to any great extent the sources of cultural differences between the United States and the United Kingdom. A thorough examination of the roots of these cultural differences may be useful, especially since anti-statist sentiment is still a major component of the cultural framing of arguments in the United States (AP 2009; Neuman 2009). Similarly,

Americans still have a strong aversion to “socialism” (Newport 2010). Undoubtedly, then, scholars have no shortage of inquiries to pursue.

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